

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

BILL COOP,

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Respondent.

) Case No. DISM-98-0061

)
) FINDINGS OF FACT, CONCLUSIONS OF
) LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair; GERALD L. MORGEN, Vice Chair; and LEANA D. LAMB, Member. The hearing was held at the office of the Personnel Appeals Board in Olympia, Washington, on January 25 and 26, 2000.

1.2 **Appearances.** Appellant Bill Coop was present and was represented by Anita L. Hunter Attorney at Law, of Parr & Younglove, P.L.L.C. Respondent Department of Social and Health Services was represented by Mickey Newberry and Colin Jackson, Assistant Attorneys General.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of dismissal for neglect of duty, insubordination, malfeasance, gross misconduct and willful violation of published employing agency or department of personnel rules and regulations. Respondent alleges that Appellant used

1 excessive force while restraining a resident and failed to report allegations of child abuse to the
2 Child Protective Services.

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4 1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084
5 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Countryman v.
6 Dep't of Social & Health Services, PAB No. D94-025 (1995); Parramore v Dep't of Social &
7 Health Services, PAB No. D94-135 (1995); Rainwater v. School for the Deaf, PAB No. D89-004
8 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994); Aquino v.
9 University of Washington, PAB No. D93-163 (1995); Holladay v. Dep't of Veterans Affairs, PAB
10 No. D91-084 (1992).

11 12 **II. FINDINGS OF FACT**

13 2.1 Appellant Bill Coop was a Juvenile Rehabilitation Residential Counselor and permanent
14 employee for Respondent Department of Social and Health Services at the Naselle Youth Camp.
15 Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated
16 thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals
17 Board on November 16, 1998.

18
19 2.2 By letter dated October 27, 1998, Thomas Quinn, Superintendent of the Naselle Youth
20 Camp, informed Appellant of his dismissal. Mr. Quinn charged Appellant with neglect of duty,
21 insubordination, malfeasance, gross misconduct and willful violation of the published employing
22 agency or department of personnel rules and regulations. Mr. Quinn alleged that Appellant 1) used
23 excessive force while restraining a resident and 2) failed to report allegations of child abuse to the
24 Child Protective Services.

1 2.3 Appellant began his employment with the Naselle Youth Camp (NYC), a juvenile
2 rehabilitation residential facility, in 1978. As a Juvenile Rehabilitation Residential Counselor
3 (JRRC), Appellant was responsible for caseload management of juvenile residents, and his duties
4 included maintaining the security and safety of the residents. Appellant's performance evaluations
5 from 1994 to 1998 reflect that Appellant primarily met the normal requirements of his position.

6
7 2.4 Appellant received prior discipline when he was suspended effective September 7 through
8 September 14, 1994, for inappropriately handling a resident during a crisis intervention. Appellant
9 was warned that any further incidents of the same or similar misconduct could result in further
10 disciplinary action. The letter reminded Appellant of his duty to promote a change of resident
11 behavior by using appropriate intervention, to treat residents with respect and dignity, and to ensure
12 that residents were treated in a safe manner.

13
14 2.5 Appellant attended a five day course entitled "Dealing with Resistive Youth" (DRYE
15 Training) in 1995. He also attended two, one day refresher courses in April 1997 and September
16 1997. The agency's DWRY Training emphasizes that employees should evaluate a crisis situation
17 and attempt to first verbally de-escalate the situation. If verbal de-escalation is unsuccessful,
18 physical restraints can be used to gain control over a resident. The primary goal of the training is
19 to minimize injury to staff and residents during a crisis.

20
21 *Incident #1*

22 2.6 The specific allegations listed in the disciplinary letter which in part led to Appellant's
23 dismissal are as follows:

24 On January 7, 1998, . . . resident Zach G. was physically restrained . . . Both
25 while Zach was having handcuffs applied and also when he was being escorted to
26 the isolation unit by you, you applied pressure to Zach's wrist causing him pain
and injury. Additionally, when Zach was handcuffed, face down on the bed in the

1 isolation unit, and not physically resisting, you said, “unless you control yourself,
2 then I’ll control you.” You then sat on the small of Zach’s back while applying
3 pressure to his hands. Zach complained you were hurting his wrist. You got off
4 Zach and asked for a commitment from him to not scream and bang. Zach
5 remained passive but would not reply to you. You again sat on the small of
6 Zach’s back while maintaining the pressure on Zach’s wrist. . . .

7 2.7 In determining the facts in this case, we have considered the appointing authority’s
8 testimony that abuse of Zach occurred only when Appellant sat on Zach’s back while in the
9 isolation room, causing pressure to Zach’s arms/wrists which were handcuffed behind his back.

10 2.8 On January 7, 1998, Appellant was working in the Moolock lodge at the NYC. Resident
11 Zach, approximately 15 years old, had been acting out that day and had been warned on two
12 separate occasions by JRRCs Matt Scrabeck and Clay Haws that he should calm down or he would
13 be sent to the isolation unit. Sometime after 7 p.m., Zach was heard yelling out the window of his
14 room. Based on Zach’s disruptive behavior, Appellant, Mr. Scrabeck, Mr. Haws, and JRRC Jerry
15 Elliott, went to Zach’s room to move him to a secure area in the isolation unit.

16 2.9 Appellant and Mr. Elliott restrained Zach. Appellant placed Zach’s arms behind his back
17 and placed handcuffs around his wrists. Zach was asked to cooperate by walking from his room to
18 the isolation room, however, Zach would not cooperate and was “static resistive.” While Zach was
19 transported from his room to the isolation unit, Appellant walked alongside him and applied a
20 “gooseneck” hold on Zach’s wrist. The “gooseneck” hold, an authorized pain compliance
21 technique, is used by staff to gain control over a resident by applying pressure to the wrist joint by
22 compressing the hand towards the forearm. During the escort, Appellant applied pressure to the
23 gooseneck hold when prompting Zach to keep walking. During this time, Zach remained
24 disruptive and yelled out profanities. Although Zach continued to be static resistive, he was not
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1 physically aggressive. Mr. Elliott, Mr. Scrabeck and Mr. Haws were available to assist Appellant if
2 necessary.

3
4 2.10 Zach was a self mutilator and when staff arrived at the isolation room, they changed him
5 into sweat pants to ensure that he had no objects hidden in his jeans which he could use to cause
6 injury to himself.

7
8 2.11 Prior to leaving Zach alone in the isolation room, Appellant and Mr. Elliott asked him to
9 make a commitment that he would not yell, bang or do anything that would cause injury to himself.
10 Zach became silent and would not engage in any communication. Zach was not struggling or acting
11 out physically.

12
13 2.12 Appellant placed Zach, whose hands were still cuffed behind his back, face down on the
14 isolation room bed. Because Zach would not make a commitment, Appellant sat on Zach's lower
15 back for approximately five to ten minutes. During this time, Appellant continued to apply the
16 gooseneck hold on Zach's wrist without applying pressure. Mr. Scrabeck held down Zach's legs
17 while Appellant sat on him. Appellant stated to Zach that he would get off his back if Zach gave
18 him the commitment. Zach continued to be silent.

19
20 2.13 When Mr. Scrabeck noted that Zach was no longer resisting, he determined that it was not
21 necessary to continue restraining Zach. He commented that they should leave Zach alone. Mr.
22 Scrabeck left the isolation unit and Appellant and Mr. Elliott left shortly thereafter.

23
24 2.14 Beginning with the initial take down and during the course of the incident, Zach complained
25 of pain to his wrists. However, he refused to be examined by the on-duty nurse that night. The
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1 following day Zach was examined by a physician who noted that there was redness and bruising
2 around Zach's left wrist.

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4 2.15 It is uncontroverted that most residents complain of some form of pain or discomfort during
5 a take down and that handcuffs can cause redness, tenderness and bruising to the resident's wrists.

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7 2.16 NYC has adopted Policy #2 which provides guidelines for the physical restraint of a resident
8 acting out. Section 2-300 of the policy states:

9
10 This policy . . . provides additional guidelines for the physical restraint of acting out
youth, including use of mechanical restraints.

11

12 Corporal punishment, physical abuse and use of physical restraint/mechanical
13 restraints as punishment is prohibited. Youth who are out of control and/or pose a
14 threat to the safety of themselves, others or property may require physical handling
but verbal diffusion shall have been tried first. **The least amount of force
15 necessary to gain control of the situation shall be used.** . . . The safety of
physical restraints of residents and staff shall be ensured. . . .

16

17 Staff shall initially attempt to defuse an out of control youth.

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20 Should physical restraint become necessary, a "back-up" call shall be made if
insufficient numbers of staff are available at the time.

21

22 A lead staff will provide a plan and delegate responsibilities.

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25 The youth should be given a final chance to comply.

1 Staff shall make it clear to the youth what will happen if he continues to resist. This
2 can be done by the slow, clear reading of the Statement of Intent . . . or more
3 informally using whatever might reasonably strike a note of cooperation with the
4 youth. **This will be left to the judgment of staff involved.** The important issue is
that the youth is informed that this is his last chance to cooperate, that he will be
physically restrained if he refuses to comply and that he may be referred for
prosecution if he becomes assaultive.

5 (Emphasis added)

6
7 2.17 It is a standard operating procedure at NYC to sit on a resident who is a risk of hurting
8 himself or others. However, Respondent has established that it is not acceptable to sit on a client to
9 elicit a commitment from the resident.

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11 2.18. Appellant understood the agency's policy and procedures regarding the physical restraint of
12 a resident.

13
14 2.19 Appellant testified that while in the isolation room, he sat on Zach's back because of staff
15 concerns that Zach could harm himself. However, the evidence established that once in the
16 isolation room, Zach was prone face down on the bed with his hands cuffed behind his back and he
17 was quiet, inert and non-combative. Furthermore, staff had taken precautionary measures by
18 changing Zach into sweat pants to ensure that he had no objects hidden which he could use to hurt
19 himself.

20
21 2.20 Respondent has established that once Zach was placed on the bed, he had been sufficiently
22 restrained and staff had met its goal to gain control of the crisis while minimizing any risk to Zach
23 and staff. Appellant used more force than necessary to gain control over Zach by sitting on him in
24 order to get a commitment. However, Respondent failed to establish that the redness and bruising
25 around Zach's left wrist was caused by Appellant's actions in the isolation room.

1 2.21 The incident involving Zach was reported to the Child Protective Services (CPS) on January
2 9, 1998. The CPS investigation dated May 12, 1998 concluded that Appellant used excessive
3 restraint on Zach during the incident. Effective May 19, 1998, Appellant was placed on home
4 assignment and a Personnel Conduct Report was initiated to investigate the allegation that
5 Appellant physically abused Zach during the physical restraint on January 7, 1998.

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7 *Incident #2*

8 2.22 On June 12, 1998, Appellant filed a grievance which stated as follows:

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10 Nature of Grievance:

11 It is my understanding that a manager had been romantically involved with a
12 resident at Naselle Youth Camp. I have received information that this manager
13 was involved in questionable behavior with the resident. I have heard this
manager was seen by another resident, touching the first resident inappropriately
or visa versa.

14 I have heard this was not reported/referred to C.P.S. I have heard this was
15 investigated internally and dropped. I want to know why this was not referred to
16 C.P.S.? I want to know why some cases are referred to C.P.S. and some are not?
Are some of those doing the investigation in violation of the law? I will only
disclose who this manager is to an outside agency.

17
18 Remedy Requested:

19 I want this case and all cases that have been dealt with in this manner
20 investigated & determination if there has been a violation of the law by not
reporting this to law enforcement and/or C.P.S.

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22 2.23 On the afternoon of June 12, Denny Moore, Appellant's supervisor, spoke to Appellant
23 about the allegation of an inappropriate relationship between staff and a resident in his grievance.
24 Although Appellant had heard the rumors, he did not suspect that child abuse had occurred.
25 Appellant he would not disclose the names of the employee or of the resident. Mr. Moore directed
26 Appellant to file a report with CPS.

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2 2.24 On June 15, Don Gauntz, Juvenile Rehabilitation Program Manager, initiated a call to
3 Appellant at his home to discuss the allegations in the grievance form and to ensure that appropriate
4 steps were taken to protect residents. Appellant refused to report any names to Mr. Gauntz. During
5 the conversation, Appellant informed Mr. Gauntz that he had filed a complaint with CPS.

6
7 2.25 Mr. Gauntz made a number of subsequent calls to CPS to determine whether a referral had
8 been filed by Appellant. Although he verified that Appellant had made contact with a number of
9 employees at CPS, Appellant had not filed a complaint of alleged child abuse.

10
11 2.26 As of June 19, 1998, Mr. Gauntz was still unable to verify that Appellant had reported the
12 allegation. As a result, Mr. Gauntz completed a CPS referral form which described the allegation as
13 described by Appellant in his grievance form. Mr. Gauntz faxed the form to the CPS office on June
14 19.

15
16 2.27 On June 19, due to Appellant's failure to follow the directive to report the allegations of
17 abuse to CPS, Mr. Moore initiated a PCR against Appellant. After Appellant was served with the
18 PCR, he gave Mr. Gauntz a CPS referral form which contained the names of the staff member and
19 resident which Appellant alleged had inappropriate romantic contact. On June 22, 1998, Mr.
20 Gauntz faxed Appellant's referral form to CPS.

21
22 2.28 The individuals and the incident which Appellant referred to in his grievance form had been
23 the subject of an investigation by the agency in 1997, which concluded that the allegation was
24 unfounded. The incident became the subject of rumor and discussion among NYC staff, including
25 Mr. Moore who had relayed information regarding the incident to Appellant. When Mr. Moore
26 read Appellant's grievance he presumed that Appellant was referring to the prior incident.

1
2 2.29 Mr. Quinn became the Superintendent at NYC on May 1, 1998. Mr. Quinn credibly
3 testified that when he read Appellant's June 12, 1998 grievance form, he had no knowledge of the
4 identity of the individuals to which Appellant referred. As the investigation into whether Appellant
5 had reported the incident to CPS progressed, the prior incident and the names of the individual's
6 were disclosed to Mr. Quinn. However, because Appellant's grievance did not provide any specific
7 names, Mr. Quinn could not verify that it was the same individuals or the same incident. Mr. Quinn
8 testified that the institution had an obligation to treat the allegation as a new, unreported incident, or
9 assume that it was a continuation of the previous incident and take appropriate steps to properly
10 notify CPS. Mr. Quinn testified that based on state law and agency policy, the institution was
11 required to immediately report all allegations of abuse to CPS and to ensure residents were safe
12 from harm and abuse.

13
14 2.30 The agency has adopted Administrative Policy #8.02 which requires that an employee
15 immediately notify the appropriate supervisor or manager when they suspect that client abuse has
16 occurred. The agency has also adopted Administrative Policy #9.01 which requires that an
17 employee immediately report any serious or emergent situation to his or her supervisor "during
18 office hours or on the next working day following a non-office hours incident, the employee shall
19 describe in writing the nature of the incident and the action taken within 24 hours of the incident
20 occurring." Appellant was aware of these reporting requirements.

21
22 2.31 Mr. Quinn was Appellant's appointing authority. In determining if discipline was
23 warranted, he considered the allegations presented in the personnel conduct reports, the
24 investigative reports, Appellant's personnel file, performance evaluations, commendations, and his
25 prior suspension. When reviewing the incident with Zach, Mr. Quinn concluded that Appellant was
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1 abusive when he sat on Zach and put pressure on his arms and wrists. Mr. Quinn viewed
2 Appellant's actions as unnecessary and contrary the training he had received.

3
4 2.32 Mr. Quinn also noted that the incident with Zach was similar to the incident for which
5 Appellant was previously suspended. Mr. Quinn reviewed the suspension letter which Appellant
6 received in 1994 and concluded that Appellant failed to modify his behavior despite the stern
7 warning that conduct of a similar nature would not be tolerated. He concluded that disciplinary
8 action on this incident was warranted.

9
10 2.33 When reviewing the second incident, Mr. Quinn concluded that Appellant was given a clear
11 directive to file a CPS report and that he had no basis for failing to follow this directive. Mr. Quinn
12 testified that management had a duty and responsibility to report all allegations of resident abuse to
13 CPS and that Appellant was refusing to comply with this duty. Mr. Quinn determined that
14 disciplinary action on this incident was also warranted.

15
16 2.34 Mr. Quinn testified that he considered dismissal the appropriate action because it took
17 Appellant out of the position to cause further harm to residents.

18 19 **III. ARGUMENTS OF THE PARTIES**

20 3.1 *Incident #1.* Respondent asserts that Appellant used excessive force to restrain Zach who
21 posed no harm to himself or others and was not physically aggressive or out of control once on the
22 isolation room bed. Respondent argues that Appellant had received prior discipline for a similar
23 incident in which he used too much force during the restraint of a resident and that he had been
24 warned that future misconduct of a similar nature could result in disciplinary action. Respondent
25 argues that Appellant was a long-term employee who understood the agency policy that he was to
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1 use the least amount of force necessary during a restraint and that his actions with Zach were
2 egregious and unjustified.

3 *Incident #2.* Respondent argues that Appellant was insubordinate when he refused to follow
4 his supervisor's directive to file a CPS report regarding allegations he made that a staff member was
5 behaving inappropriately with a resident. Respondent argues that the institution had an obligation
6 to ensure that any suspicion of abuse be reported to CPS. Respondent argues that even if
7 management had some idea of who the individuals involved were, it was unable to verify names
8 because Appellant refused to divulge them.

9
10 3.2 *Incident #1.* Appellant denies that his actions with Zach were abusive. Appellant argues
11 that it was an appropriate practice at NYC to sit on residents who were out of control,
12 uncooperative or at risk of hurting themselves or others. Appellant asserts that in this case, he was
13 concerned that Zach might smash his head on the wall of the isolation room, and he sat on him in
14 an attempt to get Zach to promise that he would not hurt himself. Appellant asserts that he avoided
15 sitting on Zach's hands when he sat on his back. Appellant asserts that his actions were appropriate
16 under the circumstances.

17 *Incident #2.* Appellant argues that he filed a grievance based on his belief that management
18 was selectively reporting alleged resident abuse to CPS rather than reporting all alleged incidents of
19 abuse. Appellant asserts that he knew that the incident he referenced in the grievance form had
20 been investigated by management, however, he believed that management was violating its duty to
21 report the incident to CPS. Appellant argues that when he contacted CPS, it was to report the
22 agency's failure to report allegations of abuse not to report an incident he did not believe occurred.

23 24 **IV. CONCLUSIONS OF LAW**

25 4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter
26 herein.

1
2 4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting
3 the charges upon which the action was initiated by proving by a preponderance of the credible
4 evidence that Appellant committed the offenses set forth in the disciplinary letter and that the
5 sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of
6 Corrections, PAB No. D82-084 (1983).

7
8 4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her
9 employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't
10 of Social & Health Services, PAB No. D86-119 (1987).

11
12 4.4 Insubordination is the refusal to comply with a lawful order or directive given by a superior
13 and is defined as not submitting to authority, willful disrespect, or disobedience. Countryman v.
14 Dep't of Social & Health Services, PAB No. D94-025 (1995).

15
16 4.5 Malfeasance is the commission of an unlawful act, the act of doing what one ought not to
17 do, or the performance of an act that ought not to be done, that affects, interrupts, or interferes with
18 the performance of official duty. Parramore v Dep't of Social & Health Services, PAB No. D94-
19 135 (1995).

20
21 4.6 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to
22 carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

23
24 4.7 Willful violation of published employing agency or institution or Personnel Resources
25 Board rules or regulations is established by facts showing the existence and publication of the rules
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1 or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the
2 rules or regulations. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

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4 4.8 *Incident #1.* Respondent has proven that Appellant's actions were abusive when he used
5 more force than necessary to restrain Zach, who was already compliant and under control, when he
6 sat on him in an attempt to elicit a promise that he would not hurt himself. Respondent has failed to
7 prove by a preponderance of the credible evidence that Appellant's actions caused the bruising and
8 pain to Zach's left wrist. Respondent has met its burden of proving that Appellant neglected his
9 duty and violated agency policy. However, Respondent has not met its burden of proving that
10 Appellant's misconduct rose the level of gross misconduct or that it constituted malfeasance.

11
12 4.9 *Incident # 2.* Respondent's policies require that any *suspected* child abuse be reported to
13 CPS. The record here is clear that Appellant was concerned with what he believed was the
14 agency's failure to report only selected incidents of suspected abuse rather than all suspected
15 incidents of abuse. Appellant did not believe that child abuse had occurred, and he did not feel that
16 it was necessary to report the rumor to CPS. Respondent has failed to prove that Appellant
17 willfully violated agency policy or that his behavior constituted gross misconduct or malfeasance.

18
19 4.10 Appellant had a duty to follow supervisory directives. In this case, when Respondent
20 discovered that a report had not been made to CPS, Appellant was directed by his supervisor to file
21 a referral regarding knowledge he had of an inappropriate relationship between a staff member and
22 a teenage resident. Appellant clearly understood the directive to disclose to CPS the names of the
23 individuals involved. Instead, Appellant made a number of calls to CPS regarding his perception of
24 management's failure to report all incidents of alleged abuse to CPS. Appellant's report to CPS did
25 not conform with his supervisor's instructions. Because Appellant brought forth a serious
26 allegation, Respondent had an obligation to investigate and ensure that the residents under its

1 supervision were protected from harm and abuse. Respondent had no definite knowledge or
2 assurance that the allegation which Appellant referenced had been previously investigated and
3 resolved. Appellant's refusal to follow a directive is not mitigated because he did not believe that
4 the rumored conduct had occurred. Respondent has met its burden of proving that Appellant
5 neglected his duty and was insubordinate when he failed to follow a lawful directive from a
6 superior.

7
8 4.11 Although it is not appropriate to initiate discipline based on prior formal and informal
9 disciplinary actions, including letters of reprimand, it is appropriate to consider them regarding the
10 level of the sanction which should be imposed here. Aquino v. University of Washington, PAB No.
11 D93-163 (1995).

12
13 4.12 In determining whether a sanction imposed is appropriate, consideration must be given to
14 the facts and circumstances, including the seriousness and circumstances of the offenses. The
15 penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to
16 prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the
17 program. Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

18
19 4.13 In determining whether the sanction imposed here is appropriate, we have weighed
20 Appellant's long history with the department, his previous discipline, his performance evaluations,
21 the appointing authority's testimony and the proven charges. Appellant's dismissal letter makes a
22 number of serious allegations regarding incident #1, including the assertion that Appellant was
23 abusive and caused pain to Zach during the initial take down and during the escort. Based on the
24 evidence presented to us and based on Mr. Quinn's testimony, we have before us only the allegation
25 that Appellant used too much force and caused pain to Zach when he sat on his back. Although we
26 have concluded that Appellant's actions went beyond what was necessary to restrain Zach, the

1 method he employed to do so, sitting on him, was a standard operating procedure which was neither
2 prohibited by training, management nor by agency policy. Furthermore, the agency's policy
3 authorizes employees to exercise their own judgment when restraining a child who is acting out and
4 refusing to cooperate with staff directives. Respondent has failed to meet its burden that
5 Appellant's misconduct rose to a level of gross misconduct or constituted malfeasance.

6
7 4.14 In the second allegation, Appellant was specifically charged with failing to follow his
8 supervisor's directive to file a CPS report. However, Respondent failed to prove that Appellant's
9 misconduct, which we found was insubordinate and a neglect of his duty, violated policy, rose to a
10 level of gross misconduct or constituted malfeasance.

11
12 4.15 Both Respondent and Appellant have a duty and responsibility to ensure the safety of the
13 children in their care and to ensure that they are free from harm and abuse. In this case, where
14 Respondent has failed to meet its burden of proof with respect to several of the allegations and
15 charges and where Appellant had 20 years of state service, dismissal is too severe. Nonetheless,
16 Appellant had received one prior disciplinary action and he was warned about the need to follow
17 agency policy when restraining clients. He was further warned of the consequences of future
18 misconduct for similar behavior.

19
20 4.16 The mitigating factors notwithstanding, the seriousness and circumstances of the proven
21 charges warrants a severe disciplinary sanction. We find that a lengthy suspension is sufficient to
22 prevent recurrence, to deter others from similar misconduct and to maintain the integrity of the
23 program. Therefore, the disciplinary sanction should be modified to a six-month suspension.

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V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Bill Coop is modified to a six-month suspension.

DATED this _____ day of _____, 2000.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Walter T. Hubbard, Chair

Gerald L. Morgen, Vice Chair

Leana D. Lamb, Member